U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE "VALUE ADDED" OF LINKING PUBLICLY ASSISTED HOUSING FOR LOW-INCOME OLDER ADULTS WITH ENHANCED SERVICES:

A LITERATURE SYNTHESES AND ENVIRONMENTAL SCAN

January 2012

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THE "VALUE ADDED" OF LINKING PUBLICLY ASSISTED HOUSING FOR LOW-INCOME OLDER ADULTS WITH ENHANCED SERVICES:
A Literature Syntheses and Environmental Scan

The Lewin Group

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EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Office of Disability, Aging and Long-Term Care Policy, in partnership with the U.S. Department of Housing and Urban Development (HUD) and the Administration on Aging (AOA), engaged the Lewin Group and its sub-contractors, Leading Age Center for Applied Research, the Moran Company, and Mary Harahan to develop design options for a demonstration of publicly assisted rental housing coordinated with health and long-term care services and supports for low-income older adults.

This effort stems from the hypothesis that publicly assisted senior housing can act as an effective platform for organizing a system of coordinated health and long-term services and supports for low-income older adults.

This effort stems from the hypothesis that publicly assisted senior housing can act as an effective platform for organizing a system of coordinated health and long-term services and supports for low-income older adults. Combining publicly assisted housing with health and long-term services and supports responds to the preferences of most residents and their families to remain in an independent living setting, even as they age and their health declines. By building off an existing infrastructure--already built low-income housing and, in many buildings, an already paid for services coordinator--publicly assisted senior housing provides the core of a potentially less costly system of affordable housing linked to services. Because publicly assisted housing also provides a critical mass of elderly residents living in close proximity to one another, this creates opportunities to achieve important economies of scale in organizing, purchasing, and delivering services, thereby increasing efficiency and affordability. Incorporating the surrounding community into housing with services strategies may further increase the power of the strategy to improve public health and lower health and long-term care costs.

This paper uses the term "publicly assisted housing" to refer to independent unlicensed publicly subsidized rental housing that provides affordable rent to very low-income seniors.

Hundreds of publicly assisted, largely not-for-profit housing providers and several states and private sector organizations have developed programs to bring enhanced services to residents. Innovative housing providers across the country, working with federal, state, and community partners have, largely at their own initiative, developed

many prototypes of publicly assisted with enhanced services for older adults. Typically, these programs are based on the property's employment of a service coordinator (available through HUD grants and in some cases incorporated into the properties operating budget), complimented by a wide array of community partnerships.

Federal Publicly Assisted Housing Programs

The federal programs that provide the majority of publicly assisted rental housing for low-income seniors include:

- ***Section 202 Housing for the Elderly***--This program provides the only federally funded housing specifically for persons age 62 and older (estimated 263,000 residents) and largely targets seniors earning less than 30% of the area median income, which equated to less than $15,000 in income in 2009 (DeNavas-Walt, Proctor, & Smith, 2009). Although HUD housing assistance programs generally do not provide supportive services to the elderly, sponsors of Section 202 (which subsidizes the development and operating costs of multifamily properties for elderly households with very low incomes) properties must demonstrate that services will be available at the development or in the community of the proposed new construction. The majority of 202 properties can accommodate residents as they become frailer. According to a 2006 AARP survey, most (74%) have grab bars and one-way emergency call systems (88%), almost all have ramps or a level entrance, and almost half of all units are wheelchair accessible. Over 90% have some communal space, about half have space for congregate meals and/or other supportive services, and about 56% have a services coordinator (Kochera, 2006). Services are also somewhat more common in 202s than in Low-Income Housing Tax Credit (LIHTC) properties targeting older people. For example, about 75% of Section 202s had a laundry facility, compared to 70% of LIHTC properties for older persons. Seventy-three percent of 202 properties had social/recreational activities arranged or provided by management, compared to 60% of LIHTC properties for older persons and 30% of other types of LIHTC properties. Thirty-four percent of Section 202 properties for older persons provided or arranged for transportation for their residents, compared to 22% of LIHTC properties for older persons and 6% of other types of LIHTC properties (Kochera, 2006).

- ***Low-income Housing Tax Credit Program (LIHTC)***--Roughly 24% of the LIHTCs' 23,000 rental projects (5,500) are intended primarily for older persons. However, very low-income seniors largely cannot afford tax credit properties without additional subsidies. States administer the program under policies developed in a "Qualified Allocation Plan" (QAP), which sets the criteria for allocating tax credits. Using the QAP, states can promote various policy objectives, including designating the proportion of credits allocated for various populations. As discussed above, LIHTC properties for older persons are somewhat less likely than 202s to have features that aid residents to age in

place. In 2006, only 26% of LIHTC properties had a services coordinator on staff, compared to 56% of 202s, and 54% of LIHTC properties did not offer any services (Kochera, 2006).

- ***Public Housing***--This federal program offers housing assistance to poor seniors through locally designated Public Housing Agencies that own the properties. Seniors represent 31% of participating households (about 330,000 persons), and over half live in projects specifically designated for seniors (HUD, 2008). With some important exceptions, unlike Section 202, public housing was not intended to provide the flexibility needed to address the changing needs of seniors and a significant portion of the properties are becoming physically and functionally obsolete. No new units have been built since 1994.

In addition to the above property-based publicly assisted housing programs, about 334,000 older renters receive Housing Choice Vouchers enabling them to rent housing in the private market (HUD, 2008).

Characteristics of Publicly Assisted Housing Residents

In 2011, baby boomers began reaching age 65. In general, the available data show an increasingly aging and frail population in publicly assisted senior housing settings. The aging of the population has widespread implications for housing sponsors. As observed by Heumann et al. (2001):

> "The increase in average resident age, the increase in residents aged 85 and older, and the fact that projects are admitting older applicants have far-reaching implications for the management, staff training, and service orientation. Older tenants are likely to require unique support and services as well as barrier-free and supportive physical design."

About 1.8 million older adults, mostly low-income single women in their mid-70s to early 80s, live in federally subsidized housing--more than the number living in nursing homes (Redfoot & Kochera, 2004). In 1999, an AARP survey estimated that 30% of Section 202 renters were over age 80 (16.3% were age 81-85, and 13.7% were over 85) (Heumann, Winter-Nelson, & Anderson, 2001). The median age of publicly assisted senior renters ranged from 74 in Section 202s and public housing to 69 in the voucher program and 68 in LIHTC properties. In HUD Section 202 properties, the average age increased from 72 years in 1983 to 75 years in 1999; in the oldest buildings (those built before 1975), the average age of residents was 78.2 years in 1999, and almost 39% were over the age of 80.

In a 1999 AARP survey of 202 housing managers, property managers reported that significant proportions of senior housing residents (36% in Section 202 properties and 38% in LIHTC properties) had difficulty walking or performing everyday tasks and that 30% ended up transferring to a nursing home (Heumann et al., 2001). Extrapolating from AARP survey data, Haley, Gray, and Taghavi (2008) projected that about 90,000

of the 278,000 202 residents (32.4%) are at risk of institutionalization. (The projection is likely a vast overstatement given the limited number of nursing home transfers (30%) that occur each year).

While the majority of publicly assisted housing residents are relatively healthy, results from the 2002 American Community Survey found over half of respondents reported limitations in activities like walking and climbing stairs, and one-third reported difficulty with shopping or going to the doctor (U.S. Census Bureau, 2002).

Wilden and Redfoot (2002) reported that older adults in subsidized housing were likely to have a number of risk factors for institutionalization including being older, being female, having low income, having a disability, and living alone. Using data from the 2002 American Community Survey, the authors found that older renters receiving subsidies were twice as likely as home owners to experience activity limitations. Estimates prepared for the U.S. Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (2002) showed that a third of subsidized renters had some difficulty with activities of daily living (ADLs) and 12% had a mental or cognitive disability that interferes with everyday activities. Data from the 1995 Survey of Asset and Health Dynamics Among the Oldest-Old (Wave 2) shows that subsidized older residents report being in poorer health than unsubsidized renters, experience more chronic conditions, have significantly higher numbers of limitations in their ability to carry out basic ADLS and instrumental activities of daily living (IADLs), and are less likely to live in properties offering services, compared with unsubsidized renters (Gibler, 2003).

Federal policy interests in publicly assisted housing with enhanced services

- *Meeting the needs of aging publicly assisted housing residents*
- *Responding to preferences of older adults and people with disabilities to age in place and the* Olmstead *mandate*
- *Increasing cost-effectiveness*
- *Improving integration and coordination of housing services, health care, and long-term services and supports*
- *Improving residents' safety, quality of care, and quality of life*
- *Reducing unnecessary hospital and nursing home use*
- *Improving care transitions*

Federal Policy Interests in Publicly Assisted Housing with Enhanced Services

Surveys show older adults will prefer to remain in independent living settings and out of institutions as they age (Gibson et al., 2005). States and the Federal Government

have responded to these preferences by increasing investments in home and community-based (HCBS) services.

The nation's more recent economic setbacks have focused federal and state policymakers on how best to control public health care expenditures, particularly for Medicaid and Medicare, two entitlement programs that constitute an increasing share of government budgets. The costs of nursing homes and the costs of caring for the oldest adults with multiple chronic illnesses significantly contribute to high health care costs. In addition, over the past several years, HUD has become increasingly committed to using its affordable housing programs as a platform for service delivery to vulnerable populations, including the homeless, working age adults with disabilities, and seniors.

The Frank Melville Supportive Housing Investment Act of 2010 makes many changes to HUD's Section 811 Supportive Housing for Persons with Disabilities program, supporting the integration of housing and services.[1] By leveraging other sources of capital funding, such as LIHTC, the reformed Section 811 program will develop thousands more units of supportive housing every year and--for the first time--create integrated supportive housing units within affordable housing properties. HUD is moving in this direction for 202 as well.

These trends in alternative care models--the aging of the baby boomers, the preferences of seniors to maintain their independence and autonomy for as long as possible by "aging in place" in their own homes and communities, the high costs associated with nursing home care and caring for the chronically ill, and the new HUD policy goals aimed at improving the integration of affordable housing and services--may lead to improved health care quality while lowering Medicare and Medicaid costs. Publicly assisted housing with enhanced services for older adults may address a number of policy issues:

- Assisting state and local housing, health, and aging services policymakers and providers to address the security, quality of care, and quality of life concerns of a large population of low and modest-income seniors now living in publicly assisted housing.

- Offering a strategy that helps reduce Medicare and Medicaid costs associated with unnecessary hospital and nursing home use.

- Providing a housing option for individuals who are transitioning from institutions under Centers for Medicare and Medicaid Services' (CMS') Money Follows the Person Program.

[1] Technical Assistance Collaborative, December 21, 2010. "Congress Enacts Legislation to Reform HUD's Section 811 Supportive Housing for Persons with Disabilities Program." http://www.tacinc.org/downloads/Congress%20Enacts%20Legislation%20to%20Reform%20HUD's%20Section%20811%20Supportive%20Housing%20for%20Persons%20with%20Disabilities%20Program.pdf.

- Informing CMS and AOA as they design new service integration and care transitions demonstration programs authorized by the Patient Protection and Affordable Care Act (ACA).

- Complementing state efforts to develop new care programs for Medicare and Medicaid Enrollees (dual eligible).

- Encouraging hospitals and physician groups considering becoming accountable care organizations or medical homes to look to publicly assisted service-enriched housing as they build their delivery system and client base.

- Educating HUD housing providers about how to help residents prolong their independence and age in place by making use of the new reforms enacted in 2010 in the 202 program. These reforms included improving the flexibility of the services coordinator program, allowing the assisted living conversion program to be used to provide supportive services in properties not licensed as assisted living facilities (a model not explored in this review), and enabling housing sponsors and developers to pool different funding sources to finance 202 properties.

- Helping HHS implement the Community Living Initiative to promote partnerships that advance the directive of the 1999 *Olmstead* decision and deepen the focus on the relationship between HCBS and affordable medical care.

Opportunities under the ACA

New service integration and care transitions demonstrations authorized by the ACA present new opportunities that could potentially include affordable housing with services programs. Section 2602 of the ACA established the Medicare-Medicaid Coordination Office (https://www.cms.gov/medicare-medicaid-coordination/), which is charged with making Medicare and Medicaid work together more effectively to improve care and lower costs.[2] Through this office, CMS is partnering with states on several initiatives to expand access to integrated programs for Medicare-Medicaid enrollees. Some of these initiatives could potentially include affordable housing with services.

CMS launched the first initiative in this area, the State Demonstrations to Integrate Care for Dual Eligible Individuals, in April 2011, through a partnership of the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation (Innovation Center).[3,4] Fifteen states were selected to participate. CMS will provide the

[2] CMS, CHIP and Survey & Certification, Medicare-Medicaid Coordination Office, July 8, 2011. Memo to State Medicaid Directors re "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

[3] CMS, July 8, 2011.

states with funding and technical assistance to develop person-centered approaches to coordinate care across primary, acute, and behavioral health and long-term supports and services for dual eligible individuals.

Another initiative is Testing Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees.[5,6] The initiative will test two financial models for states to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and long-term services and supports for their Medicare-Medicaid enrollees. The Medicare-Medicaid Coordination Office and Innovation Center are collaborating on this initiative. The two models are a capitated model and a managed fee-for-service (FFS) model. States have an option to pursue either or both of these financial alignment models. The due date for states interested in the new financial alignment opportunities to submit a letter of intent was October 1, 2011.

Assistance to states in delivering coordinated health care to high-need, high-cost beneficiaries is available through a new technical assistance resource center, the Integrated Care Resource Center (http://www.integratedcareresourcecenter.com/).[7]

Purpose and Methods

This literature synthesis and environmental scan presents findings from peer-reviewed studies as well as unpublished reports and policy briefs. We used previous summaries of the research compiled by LeadingAge, studies available on the HUD website, and other research familiar to the study team. To identify additional relevant studies, we included literature cited in these sources. Also, we searched for updated literature on the included program models, to ensure that the included literature reflected the latest research on the topics. The review does not include all literature on this topic, but provides findings from studies of many diverse programs.

The review addressed the following questions:

- What are the different models of publicly assisted housing with services?
- What is known about the impact of publicly assisted housing with enhanced services on older adult residents?

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[4] CMS, Medicare-Medicaid Coordination Office, "State Demonstrations to Integrate Care for Dual Eligible Individuals." Webpage. http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage.

[5] CMS, July 8, 2011.

[6] CMS, Medicare-Medicaid Coordination Office, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." Webpage. http://www.cms.gov/medicare-medicaid-coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp#TopOfPage.

[7] CMS, Medicare-Medicaid Coordination Office, "Resources Available to All States to Coordinate Care for High-Cost, High-Need Beneficiaries." Webpage. https://www.cms.gov/medicare-medicaid-coordination/10_IntegratedCareResourceCenterAvailabletoAllStates.asp#TopOfPage.

- What challenges must be overcome to implement publicly assisted housing with services strategies and how can they be overcome?

- What are the knowledge gaps and recommendations for future research?

Based on full text review of included studies, we extracted information from each study about findings related to the four research questions listed above.

Details on findings related to targeting will be presented in detail in a separate paper on targeting. In the remainder of this project, findings from this literature review will be further shaped and enriched by discussions with the Technical Advisory Group (TAG) advisors, the site visits, and additional interviews with key informants.

SUMMARY OF FINDINGS

The studies examined a variety of different program models, providing a range of program characteristics to consider. However, this means that findings are not comparable across studies. Some of the key issues addressed in the literature that are relevant for designing a demonstration are summarized below.

Further details on the included studies are provided in the appendices. ***Appendix A*** provides summaries of the findings from publicly assisted housing with enhanced services programs. We paid particular attention to findings from large demonstration programs that resulted in lengthy reports examining many issues (Congregate Housing Services Program [CHSP], Hope for Elderly independence [HOPE IV]). ***Appendix B*** summarizes findings from similar programs in other settings. ***Appendix C*** provides summaries of findings from workgroups.

Program Models and Components

The literature described several aspects of program models and components to consider, including:

- Mix of services provided--The reviewed programs varied widely in the mix of services offered, such as whether they offered home-delivered or congregate meals, social/recreational activities, mental health services, transportation, health and wellness services, personal care assistance, occupational therapy, assistance with obtaining assistive technology (AT), etc.

- Project-based versus tenant-based (for example, CHSP was project-based while HOPE IV was tenant-based).

- Service flexibility versus “packaged” services--flexibility was mentioned as an advantage in some studies. Not every tenant or property can adhere to a strict service delivery system.

- Whether participants have to move to receive services or they can remain in their homes (for example, in HOPE IV about 40% of participants had to move to become eligible for the program, while in CHSP participants could remain in their homes)--residents not having to move to receive services was mentioned as a factor that facilitated buy-in in the Just for Us program.

- Congregate housing versus scattered-site--The HOPE IV evaluation suggested that HUD policies ensure a variety of housing options for frail older adults to choose from; however, this has implications for service coordination and delivery.

Benefits for Residents

Many of the studies reported program benefits for residents, including the following.

- ***Meeting unmet need for services***--A frequently mentioned benefit was helping to meet residents' unmet needs for services.

- ***Improvements on indicators of physical/mental health, functioning and independence, and well-being***--This was another frequently mentioned program benefit across many studies included in this review.

- ***Increased ability to age in place***--The literature was somewhat mixed regarding impacts on residents' ability to age in place. The HOPE IV evaluation found that the program did not appear to reduce rates of nursing home placement or increase tenure in Section 8 housing. A study of the Psychogeriatric Assessment and Treatment in City Housing (PATCH) program found no significant difference between participants and comparison group members in nursing home placement (Rabins et al., 2000). On the other hand, an evaluation of the Service Coordinator Program (SCP) found that average length of occupancy was six months longer among residents of properties with HUD service coordination than for residents of similar developments without the program (Levine & Johns, 2008). The Resident Opportunities and Self-Sufficiency (ROSS) Resident Service Delivery Models (RSDM) for the Elderly and Persons with Disabilities (EPD) reported fewer evictions among program participants than residents in properties without the program. In the Colorado programs with enhanced services studied by Washko et al. (2007), residents said the program increased their confidence that they could maintain themselves in independent living.

- ***Resident satisfaction***--Many of the housing with services studies reported high levels of resident satisfaction with the program.

Cost Impacts

Some studies examined cost impacts and found some evidence of positive results. Yaggy et al. (2005) found that the Just for Us program shifted Medicaid expenditures away from ambulances and hospital services to pharmacy, personal care, and outpatient visits. At two-year follow-up, the program was not breaking even, but it was moving toward that goal. A study of the New York Naturally Occurring Retirement Community (NORC) Supportive Service Program (SSP) found that it forestalled a reported 460 hospital stays and 317 nursing home placements, saving the state $11 million over three years (Lawler, 2001).

Benefits for Properties and Communities

Several of the studies reported benefits for properties and the community, including:

- Higher occupancy, reduce turnover, and improved maintenance of units.
- Increased integration/coordination of services, building of partnerships.
- Improved ability of properties to serve older residents, including improved ability to assess residents and develop care plans, provide and arrange services.

Program Challenges and Strategies

A service coordinator was an essential component of several of the programs.

The literature revealed many challenges to implementing housing with services programs. The good news is that the studies also described many promising strategies that programs have developed to overcome the challenges.

Funding--Funding was mentioned as a top challenge in several of the studies. Funding sources mentioned in the literature included partnerships/matches, participant fees, federal demonstration grants, and existing funding streams such as Medicare and Medicaid.

Importance of service coordinator--A service coordinator was an essential component of several of the programs. For example, the CHSP evaluation noted that the service coordinators provided a variety of types of assistance to help residents navigate the often confusing array of services and overcome resident reluctance to accept or seek assistance.

Importance of a health educator--The WellElder program included a health educator in addition to a service coordinator. Property managers suggested that health educators spend more time at the properties (Sanders & Stone, 2011).

Need for a catalyst or champion--In the May 2010 Summit on Affordable Housing and Services, one of the drivers needed to develop this program model mentioned by participants was the need for a catalyst or champion to lead the effort.

Finding people who might benefit from the program--This was a challenge for some programs. In the PATCH model, building staff or “indigenous workers” served as case finders. They were trained to look out for evidence of psychological illness in residents and refer those residents to the nurses (Rabins et al., 2000). This is consistent

with our notes from the TAG meeting of experts in May 2011. Many participants advocated for training property employees, like maintenance and janitors, to be able to identify these issues.

Recruiting and enrolling participants and overcoming resident concerns, especially in rural areas with a lower population density (Bolda et al., 2000), was another challenge. Some studies reported that resistance among some providers and residents made recruitment difficult. The CHSP and HOPE IV evaluations noted the importance of outreach by staff of the program, building, or housing authority, especially word-of-mouth outreach. The Colorado models study suggested the importance of providing lots of education and information consistently to get people involved and to address concerns.

Forming partnerships--Many studies discussed the importance of forming partnerships with various entities, including with Area Agencies on Aging (AAAs) and other aging organizations, with hospital discharge planners, and with nursing schools, universities, or colleges. In HOPE IV, for example, the service coordinator was responsible for forging relationships with local aging organizations. The WellElder program illustrated the benefit of forming relationships with hospital discharge planners (Sanders & Stone, 2011). Several of the programs involved partnerships with universities or nursing schools. Rantz et al. (2008b) noted that one of the advantages of TigerPlace was having a school of nursing undertake the project. Nursing students and other students can benefit from the relationship between University of Missouri-Columbia and TigerPlace.

Need for technical assistance and training--Another frequently mentioned issue was that housing and service providers could benefit from increased technical assistance and training. A suggestion for programs consisting of multiple sites was that program staff may find that they can learn from experiences across sites. In the HUD CHSP evaluation (Griffith, Greene, Steward, & Wood, 1996), grantees suggested that the facilitation of communication and learning among CHSP sites would be beneficial. Many of the partnerships identified between housing and service providers have not been formalized to include cross-training. In the Summit on Aging in Public Housing (2011), participants suggested that housing and service providers increase their skills and knowledge to better interact with each other and with residents. In the National Summit on Affordable Senior Housing and Services in May 2010, summit participants also suggested the development of common language/definitions to communicate goals to policymakers, regulators, and funders (American Association of Homes and Services for the Aging [AAHSA], 2010). Development of this common language and definitions would not only require collaboration, but also cross-training between housing and service providers to develop these partnerships. Additionally, in Ficke and Berkowitz's (1999) HOPE IV Evaluation, grantees suggested that HUD should supply technical assistance. In the 2011 Summit, a finding was that housing authorities and service providers need to increase their skills and knowledge to better interact with each other and with residents. This suggests that cross-training may be beneficial.

Involving residents and adapting the program to participants' needs--Several studies noted the importance of knowing and adapting the program to the needs of participants and older adults in the local community. The HOPE IV evaluation noted the importance of adapting programs based on knowledge of the specific needs of the local community. The need for data to respond to residents' changing needs was mentioned as an issue in the study of three Colorado models (Washko, Sanders, Harahan, Stone, & Cox, 2007). Bolda et al. (2000) suggested involving area residents early in project planning. Cultural and ethnic differences was discussed as an area of consideration in the WellElder evaluation (Sanders & Stone, 2011). Ficke and Berkowitz (1999) also mentioned the need for overcoming cross-cultural differences in assumptions underlying the receipt of services. Participation of residents in service planning was a goal of the new CHSP. In the March 2011 Summit, residents noted that their inside perspective can be valuable to assisting properties in identifying resident needs (Enterprise Community Partners, Inc. & LeadingAge, 2011). Knowledge of resident needs was mentioned by housing providers as an issue at the Summit.

Including family caregivers--Washko et al.'s 2007 study of three Colorado models found a high amount of family involvement with residents. The authors suggested that housing providers consider including informal caregivers as they evolve resident services strategies, including involving families in care consultation meetings and development of service plans. A 2010 study by Sanders, Stone, Meador, and Parker described the development and testing of a training program for family caregivers of residents living in affordable senior housing. The authors suggested that the development and dissemination of a successful caregiver training program could significantly improve the ability of senior housing properties to help their elderly tenants remain in their own homes. An unexpected benefit of the program was the support family caregivers gave each other when they began meeting with other caregivers whose family member lived in the same HUD-assisted property (Levine, Kennedy, & Rosenoff, 2010).

Use of health information technology--Health information technology was an important component in some programs. In the Just for Us program, for example, clinicians carried laptops when they visited residents, and electronic records were available to all clinicians (Yaggy et al., 2006). Computer software was developed to facilitate coordination of care with the hospital. In the TigerPlace program, a noted advantage of the model was that home care agency staff used an electronic information system that helped nurses better coordinate care (Rantz et al., 2008b).

Connection between housing properties and AT/home modifications (HM)--An area that could be further explored in housing with services research is the connection between housing properties and AT/HM. The draft final report from the Lewin Group's recent research for ASPE on AT/HM found that a growing number of studies have found evidence to support the effectiveness of AT/HM in helping older adults remain independent in the home and/or slow functional decline (Demiris et al., 2003; Gitlin et al., 2006; Liu & Lapane, 2009; Mann et al., 1999; Szanton et al., 2011;

Wilson et al., 2009). In Mann et al.'s study (1999), for example, AT/HM services were shown to decrease Medicaid costs and delay institutionalization.

Recruiting and retaining workers--In the May 2010 Summit, participants identified an adequate workforce as one of the needed drivers to facilitate development of an affordable housing with services program. The Annapolis Work Where You Live model is a promising strategy for recruiting and retaining direct service workers. A strategy used in some rural areas is to share staff across facilities (Bolda et al., 2000).

Policy Barriers and Recommendations

The literature mentioned several policy barriers to the expansion of housing with services programs, including:

- Restrictions in the Medicaid and Medicare programs, including lack of coverage of mental health care and occupational therapy. Another barrier mentioned was eligibility requirements that restrict the program to people who are impaired in ADLs, excluding people who need IADL assistance only. Lack of funding for registered nurse (RN) coordination was another noted barrier (Rantz et al., 2008).

- Section 8 rules that do not permit tenants to be out of their units for more than 60 days was a noted barrier in the HOPE IV demonstration presented a challenge in some cases (e.g., returning from a nursing home within 60 days).

- Lack of coordination between financing and regulation/licensing in housing and services, or a "disconnect" between housing and services programs, was mentioned as a challenge in some studies (Castle, 2008; Washko et al., 2007; Bolda et al., 2000). In their review of rural housing with services programs, Bolda et al. (2000) found that the some states' housing development agency and human service agency were run out of different departments. This created the "disconnect" between the programs, making it more difficult to coordinate housing and services.

Research Gaps and Recommendations for Future Research

The literature suggested several areas for further research, including:

- Some studies recommended additional research on which specific program components are most effective;

- Some sources recommended studies on cost-effectiveness;

- In the 2011 Summit, stakeholders discussed the need to identify ways to measure the success of these programs.

CONCLUSION

The good news is that many innovative strategies have been developed to address many of these challenges. Efforts are needed to increase dissemination and adoption of successful approaches.

Findings from this review suggest that housing with services can help meet many of the federal policy objectives mentioned in the Executive Summary of this paper. The literature also suggests many challenges to expanding publicly assisted housing with enhanced services programs. The good news is that many innovative strategies have been developed to address many of these challenges. Efforts are needed to increase dissemination and adoption of successful approaches. However, several challenges are a result of legislative or policy barriers that would require legislative or regulatory changes to address. A demonstration, perhaps in coordination with opportunities under the ACA, could test various approaches to overcoming these challenges. Findings from this review can be used to help inform a future demonstration project and other efforts to support the successful spread of housing with services to enhance aging in place for older adults.

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APPENDIX A: FINDINGS FROM PUBLICLY ASSISTED HOUSING WITH ENHANCED SERVICES PROGRAMS

HUD Congregate Housing Services Program (CHSP)

Program model: HUD's CHSP, originally funded as a demonstration program in 1979, was among the first federal initiatives to provide a comprehensive housing and supportive services package within a subsidized housing environment (HUD, 2012). HUD administers the program in coordination with the Rural Housing Service of the U.S. Department of Agriculture. Congress has continued to appropriate funds to extend existing programs to continue services for participants, but has not funded new programs since 1995. Today, 51 public housing agencies and private assisted housing owners administer 63 grants. CHSP is a project-based, rather than tenant-based program.

A "new CHSP" was authorized in 1990 (Griffith et al., 1996). The new program requires providing service responsive to resident needs and the active participation of the resident in decisions about services.

Services include service coordination, at least one hot congregate meal per day, personal assistance, housekeeping, transportation, preventive health/wellness programs, and personal emergency response systems (HUD, 2012). A service coordinator, typically a social service staff person, is responsible for assuring that participants are linked to services. Sites had considerable flexibility in the services they provide, how they offer or "package" services, and the fees they charge for services other than meals.

Eligible grantees included states, local government units, public housing authorities (PHAs), Indian housing agencies, tribally designated housing entities, and projects funded under Section 202, Section 8, Section 221(d)(3), Section 236, and Section 515 of the Rural Housing Service.

Eligible participants include frail elderly (age 62 and older) and people with disabilities residing in federal subsidized housing who are unable to perform at least three ADLs. Sites used different criteria for selecting among eligible residents.

Under the new CHSP, funding is through a cost sharing arrangement, with HUD funding up to 40% of the cost of supportive services, grantees paying at least 50% of the cost, and participants paying fees amounting to at least 10% of program costs, or up to 20% of the participant's adjusted income.

Very few CHSP participants (5.1% of elderly and 13.1% of non-elderly) participants had experienced a move in the past period of less than 6 months. Thus, CHSP participants had typically “aged in place” and not had to move to receive supportive services. In contrast, about a third of the early HOPE IV participants had moved in order to participate, many of them because they lived in housing that could not meet HUD’s Housing Quality Standards (HQS).

Impacts for residents: A 1996 evaluation of HUD’s CHSP found that both grantees and residents reported that services helped residents continue living as independently as possible in their own homes (Griffith et al. 1996). Two-thirds or more said it would be difficult to continue living as they are without assistance in toileting, getting in or out of the chair or bed, getting in or out of the shower or tub, bathing, shopping for personal needs, getting dressed, meal preparation, personal grooming, money management, home-delivered meals, eating, and housework.

Over half left the program during the two-year evaluation period. The majority of those moved to a more restrictive environment or died. These numbers were similar to attrition rates found in earlier research on frail elderly residents.

Data showed the majority of CHSP participants said program staff provided them with information on services and helped arrange for and get services for them. CHSP program staff were the most frequently mentioned source of these kinds of assistance in the resident survey. These findings indicated that CHSP was helping most participating residents learn about and gain access to needed supportive services.

The areas where the smallest percentage of residents said the program met their needs were toileting (70%) and transferring (77%), areas where assistance is needed frequently or needs to be available quickly on an as-needed basis.

Service coordinators provided a variety of types of assistance to residents and were important in helping residents navigate the often confusing array of available care and overcoming reluctance to seek or accept assistance.

The 1996 CHSP evaluation found high levels of satisfaction among participating residents (Griffith et al., 1996).

Responses for non-elderly participants were similar to those for elderly participants.

Grantees mentioned a variety of benefits of the program for residents. These included meeting service needs and housing needs; providing service coordination; enabling them to live in their homes with independence, security, and dignity; and helping reduce isolation and increase sociability. The services most frequently mentioned by service coordinators when asked what services elderly residents need or want most were housekeeping, meals, and transportation.

Impacts for programs: CHSP grantees reported that services available through the program, particularly the availability of a services coordinator, contributed to higher occupancy rates, lower turnover, and better maintenance of units.

In addition, 10 of the 21 grantees said it affected the degree of coordination among social and housing agencies in the community. Also, the majority of grantees and service coordinators said it improved the ability to assess residents and expanded capabilities to develop care plans, provide services, and arrange and monitor services. In most cases where no change was reported, a typical comment was that they already had that capability.

Challenges and strategies: In the CHSP evaluation, 11 of the 21 grantees interviewed said that raising the 50% match was one of the most significant challenges they faced in applying for new CHSP funding (Griffith et al., 1996). However, most grantees were confident that the matching funds they obtained would be reliably available for the program period. Despite difficulties some sites experienced in the start-up period, most were providing services by the end of the first year of operation. Reasons for implementation delays included time required to raise the match and get partnerships firmly in place, hiring the service coordinator, and recruiting and enrolling residents.

Ten service coordinators mentioned that residents' inability to afford services was a barrier, and ten said that the program not having enough funds was a barrier (Griffith et al., 1996). The issue of resident fees and the costs of services to residents were an important concern for CHSP. When asked about resident fees, 61.5% of service coordinators said that other service providers in the area provided free or very low cost services that residents used instead of CHSP. Half said that fees had discouraged participation by at least some residents who need the services. About a third (34.6%) said that fees had been a burden on at least some participants.

Finding residents who met the frailty requirements for eligibility was a challenge for some grantees (Griffith et al., 1996). Twenty of the 26 service coordinators interviewed said they had undertaken publicity and outreach activities to identify people who might benefit and encourage them to participate. More than two-thirds of participants said they first learned about CHSP from staff of CHSP or the building, suggesting the importance of publicity and outreach by staff of the program, building, or housing authority. Some residents (16%) learned about the program from staff of the local AAA or another local community service agency.

Some CHSP grantees reported that developing acceptance of the new program among residents was a challenge, and residents had many reasons for being resistance (Griffith et al., 1996). For example, service coordinators said some already had services, some did not fit in with congregate style or wanted to manage on their own, and some were concerned they might get evicted if they indicated needs. The report suggested this underscores the importance of active outreach.

Grantees suggestions of ways to improve CHSP included:

- Reduce the number of ADLs required for eligibility;
- Reduce fees, or allow communities to make choices on how to handle fees;
- Reduce the size of match required;
- Simplify application and reporting requirements and have HUD staff available who can answer questions;
- Facilitate communication and learning among CHSP sites.

HUD Hope for Elderly Independence (HOPE IV) Demonstration

Program model: HUD's HOPE IV was a tenant-based program, administered by PHAs, for persons who were not previously receiving HUD assistance (Ficke & Berkowitz, 1999). The purpose of the program was to help low-income, frail older persons maintain the highest quality of life in the community, preferably their own homes. HOPE IV was not extended after the demonstration.

In addition to providing Section 8 housing, HOPE IV provided case management through service coordinators and non-medical services (e.g., transportation, personal care, and homemaker services to residents with certain limitations in their ability to carry out routine activities).

A key feature of HOPE IV was the establishment of a service coordinator position within the PHA responsible for designing and implementing an integrated system of case management, personal care, and home management services for frail elderly Section 8 tenants. Of particular importance was the coordination of traditional Section 8 staff activities with the new case management and service components of HOPE IV. The Service Coordinator was also responsible for forging relationships with aging agencies and organizations in the community. Supporting the Service Coordinator was a Professional Assessment Committee (PAC) responsible for screening applicants for frailty and documenting need for services. Only one grantee directly delivered supportive services to HOPE IV participants. The others contracted out service delivery, and several also contracted for service coordination.

Participants could remain in their home as long as it was in the PHA area and met HUD's Section 8 quality standards; otherwise they had to move into a HUD approved rental property (Ficke & Berkowitz, 1999). Over 40% of participants moved either to meet Section 8 HQS or the rental housing requirement.

Similar to CHSP, HOPE IV funding was through a cost sharing arrangement, with HUD paying 40% of supportive services costs, grantees paying 50%, and participants, except those with very low incomes, paying 10%. A requirement of the grant was that grantees collaborate with local AAAs or other agencies in developing their applications, and these agencies were the primary source of matching funds, either as in-kind services or dollars donated for services.

In 1993, HUD awarded HOPE IV grants to 16 agencies for demonstration projects for a five-year period. The grants included a supportive services component and a rental assistance component.

Impacts for residents: Ficke & Berkowitz's 1999 evaluation of HOPE IV compared outcomes for older residents who received services through the demonstration with a group of older residents who did not receive demonstration services. Demonstration participants received a significantly higher level of services than the comparison group, and this disparity in access to care remained over time. For example, at follow-up, nearly one-third (32%) of comparison group members reported receiving no services despite high levels of frailty, compared with 7% of participants.

In addition, receipt of services was significantly correlated with improved functioning across multiple domains. For example, service participants scored significantly higher in four major mental health dimensions (anxiety, depression, loss of behavioral/emotional control, and psychological well-being), social functioning (quantity and quality of social activities), vitality (energy level and fatigue), and other measures of social well-being.

The evaluation also found that the receipt of services in the demonstration group correlated with higher social functioning and well-being and better mental health (Ficke & Berkowitz, 1999). Property managers in the public housing site reported reductions in resident conflicts related to mental illness, police calls to apartments, emergency room (ER) visits, and better social interaction.

PAC members reported that the program benefited residents through increased availability of services (mentioned by 10 of 16 PAC members) and increased ability to live independently in their own homes (mentioned by eight).

Eighty-five percent of participants at baseline, and 91% at follow-up, reported they were very satisfied with HOPE IV, and most of the remainder said they were somewhat satisfied.

However, the program did not appear to reduce rates of nursing home placement or mortality or increase tenure in Section 8 housing (Ficke & Berkowitz, 1999). The researchers noted that this finding is consistent with the assumptions in the research design and the results of prior studies showing that similar programs address quality of life and care and increasing access to services, rather than changing outcomes such as death, institutionalization, or otherwise having to leave one's home due to frailty.

A relationship was found between having a case manager and the number of services received for both participants and comparison group members, suggesting that the combination of case management and services is an effective approach to addressing the needs of a frail, elderly tenant population.

Impacts on Section 8 programs: Another program impact was that nearly all grantees reported that the Section 8 program in their PHA changed as a result of their involvement in HOPE IV. Half of the 16 grantees characterized these changes as "dramatic," "major," or "revolutionary." Grantees said that prior to HOPE IV, the Section 8 programs in their sites had discounted the frail elderly as a service population. To meet the new demands of the program, grantees made formal and informal changes in their organization and organization. For example, one PHA reduced by 50% the caseload its Section 8 staff carried when involving frail elderly tenants. Another provided formal training for Section 8 staff on the status and needs of the frail elderly using the resources of a local university.

Challenges and strategies: Many grantees took over a year to get the programs started. The largest problems were finding qualified participants, adequate housing, and linking housing and services. However, PHAs were able to overcome initial implementation problems and successfully serve persons at risk of institutionalization.

Grantees were only able to fill a few HOPE IV units through existing Section 8 waiting lists and usual recruitment methods. When they relied on referrals from the AAAs and other community agencies, combined with extensive outreach efforts, in most cases, this strategy worked. Recruitment suffered at several sites where the PHA/AAA partnership failed to develop. In many places, recruitment sped up considerably after information about the program reached the network of aging service providers and spread through word-of-mouth to the older population at large.

Just under half of responding participants first found out about HOPE IV from their local AAA or the housing authority. Only about 5% first heard about the program from impersonal sources, such as ads, radio announcements, or brochures. This supports the idea that word-of-mouth is key to the recruitment process.

Another challenge was participant attrition from the program, which increased staff time spent on outreach, recruitment, and assessment. To minimize time spent recruiting participants who never enrolled or quickly dropped out, one grantee pre-screened applicants for willingness to accept supportive services. However, some attrition was probably inevitable given the intense physical, emotional, and financial needs of this population. The relatively high turnover required that HOPE IV Service Coordinators continue their intensive recruitment and placement activities, while at the same time providing ongoing case management to current participants.

A general lesson from the 16 grantee PHAs was that they must adapt their programs to fit the needs and circumstances f the low-income, frail older persons in their communities. This includes knowledge of aspects of this population such as housing conditions, economic circumstances, family support, and lifestyle. The authors stated:

> "Any basic program model, however sound, must be shaped to fit the particular environment. Intimate working knowledge of community conditions as they affect the frail, low-income elderly is more useful than abstract projections or generic

demographic data. This detailed knowledge permits a realistic assessment of what will be required to establish a viable program for the target population in a given community, including many of the likely obstacles to be overcome."

For example, in establishing a program in a largely Mexican-American community, PHA staff had to make a number of program adaptions beyond translating materials into Spanish. Other issues included appreciating inter-generational dynamics of these families and overcoming cross-cultural differences in assumptions underlying receipt of services. The authors recommended, in most communities, knowledge of local housing conditions--including the quality and availability of appropriate housing, the proportion of renters versus owners, and current and future rental market conditions--is vital to the ability to design a viable housing program for this constituency. The report quoted a grantee who stated, "Really know your frail elderly population, not just the state level data." Another grantee noted that in making projections, the application team had not taken into account how many low-income elderly in their community own their own homes and would be reluctant to move into rental housing to meet the requirements of the program.

When asked about improvements they would recommend, six PAC members suggested expanding the program to cover additional persons or continuing it beyond the five-year period, while three said that the ADL definition should be changed to allow more elderly persons with documented needs into the program. Two respondents suggested eliminated participant fees. Three said that improvements in administrative areas would be helpful, including assistance in addressing the matching funds requirement and having computers to handle the records and reports.

The 16 grantees offered several recommendations for improving the HOPE IV program based on their experiences:

- HUD should supply technical assistance.

- HUD should change the participant fee structure--five grantees suggested that the 10% participant fee be either charged on a sliding scale or eliminated altogether.

- HUD should allow qualified existing Section 8 tenants to participate.

- HUD should fund additional unexpected costs--these included funds to pay for service coordinators' time spent recruiting, marketing, and helping participants locate and move into housing.

- Find better ways of accommodating nursing home short stays and other chronic flare-ups--three grantees specifically cited difficulties with Section 8 rules that did not permit tenants to be out of their units for more than 60 days. Participants admitted to nursing homes rarely returned home within the 60-day limit.

- Two grantees recommended restricting the PAC's responsibilities and reducing the number of PAC meetings.

- Two grantees said that requiring impairment in three ADLs was too many.

The report suggested policy implications of the evaluation, including:

- The role of the HOPE IV service coordinator was essential to the successful design and implementation of the evaluation. HUD could expand the existing SCP.

- HUD could encourage the provision of supportive services for frail elderly Section 8 tenants through linkages with other federal, state, and community-based aging programs.

- The HOPE IV demonstrations and evaluation constitute a valuable information resource, and HUD can encourage dissemination and utilization of the results through existing clearinghouse and communication mechanisms.

- To address unmet needs among Section 8 tenants, HUD could promote adoption of the HOPE IV models for existing tenants as well as new Section 8 applicants.

- HUD policies should ensure that frail elderly have a range of housing assistance options and the opportunity to choose from among them, rather than favoring congregate versus scattered-site programs.

HUD Service Coordinator Program (SCP)

Program model: Generally, services coordinators determine needs of residents, provide information and referral at resident request, link them to services, and monitor services delivery. Some are very proactive, seeking out residents who may need assistance, formally assessing needs and developing a care plan. Many experts believe they are the core of a publicly assisted housing with services model (see Levine & Robinson Johns, 2008; Golant et al., 2010).

Impacts for residents: Levine and Johns (2008) examined results from a survey of property managers of HUD's SCP in eligible multifamily developments. Based on the ratio of hours to the number of residents, each resident received 30 minutes of service coordination per week.

Impacts on residents: The study found a high level of satisfaction with the SCP and a strong perception among property managers that service coordination improves residents' quality of life. For those properties with service coordinators, the perceived benefits included: better quality of life, having advocacy, facilitating a sense of security and social cohesions, resident engagement, and reinforcing independent living.

Property managers felt that the value added of service coordinators was having a knowledgeable, well-connected individual working at the property.

Survey results indicated that the average length of occupancy was 6 months longer among residents of properties with HUD-funded service coordination than for residents of similar developments without service coordination (Levine & Johns, 2008).

HUD Resident Opportunities and Self-Sufficiency (ROSS) Resident Service Delivery Models (RSDM)

Program model: HUD's ROSS grant program links public housing residents with appropriate services. ROSS differs from the SCP in that it is designed specifically for public housing residents. The ROSS program has five funding categories, including the RSDM-EPD. Three not-for-profits received ROSS RSDM-EPD grants.

The ROSS RSDM-EPD used a similar set of strategies as the SCP and CHSP, but without reliance on an assisted living setting. ROSS RSDM-EPD provides a service coordinator and grocery delivery, whereas the SCP provides a service coordinator and CHSP provides a service coordinator, meals, and assisted living.

Impacts for residents: A 2009 study of the effects of HUD's ROSS RSDM-EPD model compared residents living in housing properties in Seattle where ROSS services were available with residents living in properties without ROSS services (Siu, 2009). The study found a statistically significant difference between the two groups with respect to social interaction, receiving treatment for chronic conditions, and fewer evictions. A large percentage of study participants were under age 62.

However, residents living in buildings with services still showed a high prevalence of chronic conditions, experienced barriers to obtaining healthy foods, and had an inadequate daily intake of fruits and vegetables. Overall, residents in communities where ROSS RSDM grant funded services were available still faced significant health problems, but less so than those in communities where the same supportive services were not available.

Supportive Services Program in Senior Housing (SSPSH)

As noted by Pynoos and colleagues (2005), in the 1980s, the Robert Wood Johnson Foundation created a SSPSH demonstration project that encouraged state Housing Finance Agencies to use their excess reserves for implementing services coordination and new services (Feder, Scanlon, & Howard, 1992). While services were based on residents' willingness to pay for them, an evaluation of the program indicated that the service coordinators successfully leveraged new resources. This suggests that the program helped increase access to services.

Senior Living Enhancement Program (SLEP)

Program model: SLEP was a collaboration between the Allegheny County Housing Authority (ACHA), the Allegheny County AAA, and the Pittsburgh Foundation (Castle, 2008). SLEP was a 24-month demonstration project, with seniors located at 12 ACHA sites. Nursing/health promotion and social service coordination were offered at these sites, along with social and recreational opportunities.

Participants had to be age 60+ to meet the AAA model of older adults who receive their services. This excluded about 10% of the sample.

Impacts on residents: The study compared users of the SLEP to non-users at baseline and two years later. The ten outcomes (or 10-keys to healthy aging) examined in the initiative to improve health of seniors were: (1) Be Active; (2) Regulate Diabetes Blood Glucose <110; (3) Stop Smoking; (4) Maintain Social Contact; (5) Participate in Cancer Screening; (6) Get Regular Immunizations; (7) Lower LDLC to <130; (8) Combat Depression; (9) Prevent Bone Loss and Muscle Weakness; and (10) Control Systolic Blood Pressure <140 (Castle, 2008). Over the 24 month study period, seniors included in the study showed improvements in a majority of the 10-keys. Significant influence was shown in four of the keys (Be Active, Participate in Cancer Screening; Get Regular Immunization, and Combat Depression). However, the authors noted that health information was available for 91% of the sample at baseline, but decreased to about 50% after two years, potentially creating a bias in the findings (Castle, 2008).

Challenges and strategies: Castle (2008) discussed barriers to service-enriched housing, primarily focusing on the bigger picture and not the SLEP.

Collaboration is needed between housing agencies and service agencies--HUD and other housing sponsors need to take more responsibility over serving the frail elderly.

The other barriers include financing and regulation/licensing procedures in housing and services that are not coordinated with each other.

SLEP was able to overcome these problems, partly because funding came from the Pittsburg Foundation. Also, the 12 sites received community buy-in due to an academic affiliation.

Castle (2008) stated that SLEP was successful because it meets the effective strategies outlined by Pynoos et al. (2005) for expanding service-enriched housing. These include: (1) increased service coordination; (2) retrofitting and modifying existing housing arrangements: and (3) using Medicaid waivers to help make housing with services more affordable.

Three Colorado Models of Connecting Affordable Senior Housing and Services

Program models: A qualitative study described, compared, and assessed the potential of three publicly subsidized senior housing properties in Colorado that evolved different services strategies to support residents as they aged and their needs changed (Washko et al., 2007). One property organized itself as a direct service provider, the second developed a rich array of community partnerships, and the third left it to residents and family members to organize their services.

Each of the properties was an affordable independent rental property designed for seniors aged 62 and above. Each was originally built with federal or state subsidies that restricted resident eligibility to low-income seniors. In addition to construction subsidies, the properties also received project-based rental subsidies. All three properties have since refinanced their initial loans and not all remain under the same income restrictions, but all three remain committed to serving low and modest-income seniors.

The research team compared the housing communities' different strategies in four areas:

- Philosophy about resident services;
- Services available and service organization, delivery, and financing;
- Types of services actually received by residents;
- The role of families in providing support.

Impacts for residents: The study was a process evaluation based on a collective case study approach, which collected data through a resident survey, participant observation, focus groups, structured interviews, and property records review. The study found that focus group participant residents in the two properties with purposefully organized services programs were more confident they could maintain themselves in an independent living setting.

The study also found residents did not use many of the available services, although more residents used services when they were available on site.

Challenges and strategies: When asked to identify possible barriers to residents' ability to age in place, housing staff at one site mentioned funding as a primary barrier. In all three properties, staff cited resistance from residents and sometimes their families as a barrier to supporting residents to age in place. Staff suggested that this may be partially because of residents' perception that if they need services, they are losing their independence. Several staff mentioned that a lot of education and information needs to be provided on a consistent basis to get people involved in activities or to use services and address concerns.

The study found a high amount of family involvement with residents and suggested that housing providers consider including informal caregivers as they evolve resident

services strategies, including involving families in care consultation meetings and development of service plans.

The research team found wide variation in the data available to housing management and staff that would allow them to systematically respond to changing needs of residents and their families over time or to tell how well the property is meeting resident needs.

This study supported previous research that housing providers were cobbling together services from a variety of public and private funding sources. The report recommended that policymakers review their regulatory and administrative policies to assess how well current programs help facilitate the development of a seamless system for providers and residents.

Also, the report recommended more systematic evaluation of the impact of affordable housing plus services models on residents, housing providers, and public and private costs. The report recommended further research to examine how services can be linked with affordable housing in the most efficient and cost-effective manner to help low-income elderly in urban, suburban, and rural communities remain as independent as possible.

Creating Affordable Rural Housing with Services

Program model: A paper by Bolda et al. (2000) reviewed housing with services in rural areas of Maine, New Hampshire, Vermont, and Massachusetts. Some of the models were subsidized assisted living. Others included state housing authority funds (Maine), HUD CHSP (New Hampshire), and the "Home in Housing" Project sponsored by the Vermont Department of Aging and Disability. Their review of these models sheds lights on rural challenges in providing affordable housing with services to older adults and people with disabilities.

Challenges and strategies: Bolda et al. (2000) identified many challenges related to affordable housing with services in rural areas. The rural-specific challenges include the demographics of rural areas, which include lower population density and more lower-income consumers. This supports the use of small facilities, which then limits opportunities for taking advantage of economies of scale for construction and service delivery. The researchers also noted that housing in rural areas may have difficulty finding qualified staff to hire. Some of these small facilities sub-contracted for services or they shared staff across facilities. Some facilities also employed live-in managers who helped provide a sense of security for tenants.

Rural areas also faced financing strategies (Bolda et al., 2000). Some facilities had to renovate older buildings, which opened the doors to historical preservation funds. However, these funds come with restrictions like construction methods or materials.

Rural housing providers also need access to financing expertise, which is typically provided by the state's housing finance agency.

Some rural housing providers also needed to ensure local/community support (Bolda et al., 2000). One strategy for ensuring this is to involve area residents in the early planning of the project.

Many rural areas did not have as much trouble funding and providing housing, as they did services (Bolda et al., 2000). Funding sources for services were more limited. Many states relied on their Medicaid waiver programs; however, that excludes certain residents who are not medically eligible or requires those that are to spend down their assets to meet eligibility guidelines. Regular Medicaid is not as restrictive for medical eligibility--again, this requires residents have very low-incomes/assets to quality, though. In some states, Bolda and colleagues found a "disconnect" between the state's housing development agency and its human services agency, not allowing for an easy coordination of services with housing.

Bolda et al. (2000) suggested that state policies and programs need to directly address the unique challenges faced in rural communities to provide affordable housing with services. They stressed that as states continue to work on this kind of service delivery, they need to ensure that rural residents' needs are considered.

WellElder

Program model: The WellElder program is located in four low-income senior housing properties in the San Francisco Bay area operated by Northern California Presbyterian Homes and Services and Bethany Center (Sanders & Stone, 2011). One of the properties was developed through Section 202 funds, and the other three were developed through Section 236. The model pairs a nurse health educator with a service coordinator already operating in the housing property. The goal is for the health educator to enhance the service coordinator's capacity by applying her skills in assessing health-related needs, knowledge of health-related services and resources, and an ability to communicate with the medical community. Each property has a resident service coordinator and nurse health educator, who provide one-on-one assistance to residents.

The health educator also monitors vital signs, provides health education, medical coordination, assessments, discharge coordination, and supportive counseling. The service coordinator provides assessments, benefits assistance, bill reconciliation, supportive counseling, outreach, follow-up/monitoring, discharge planning, medical coordination, legal form assistance, grief and loss support, and emergency health information sheets.

No eligibility criteria or fees are required to participate in WellElder for residents living in the property.

Assistance is primarily provided through one-on-one contacts. No appointments are required and residents may drop by the service coordinator or health educator office anytime during their working hours.

While residents primarily initiate contact, program staff also reach out to residents who are facing health problems if they have not seen them in a while. Other property staff, such as security guards or maintenance workers, also alert program staff if they observe a resident who appears to need some additional help. Contact with residents usually occurs in the service coordinator's or health educator's office, but may also take place over the phone or in a resident's apartment. Program staff also visit residents in the hospital or nursing facility. In most cases, the service coordinator and health educator meet separately with residents.

The WellElder team conducts/organizes group education sessions by outside entities, which include a "Wellness for You" program. Topics are identified by staff and by residents and may run the gamut from yoga classes to sexuality at older ages, cancer and diet, dental health, and managing osteoporosis. Health educators produce a biannual newsletter, which addresses topics like arthritis, and balance.

Impacts on residents: Feedback from staff and residents suggest that the program helped increase access and quality of services for residents, helped them feel safer and more secure, and helped them stay in their apartments longer. The WellElder staff believed residents the program benefited residents in many ways (Sanders & Stone, 2011). These included:

- Access and maintain benefits and services;
- Improve self-care abilities;
- Facilitate communication with health care providers;
- Enhance sense of empowerment;
- Support transitions home from the hospital or nursing home;
- Increased sense of security.

In a resident survey, many residents across the four properties reported that the program helped them find out about resources and services (66.7%) (Sanders & Stone, 2011). Participants reported a higher use of transportation, personal care, homemaker, exercise, and case management services than non-participants. Also, 62.5% reported they were helped through getting services and assistance quicker than they could on their own. They also felt safer knowing that someone was available to answer their questions (66.2%). Almost two-thirds (65%) stated that they would be able to stay in their apartment longer because of the assistance they received from the nurse and service coordinator. In focus groups, participants supported these statements. When asked why they did not use the health educator more often, some stated that they felt they got the information they needed from their doctor or that she was not available that often.

Benefits to the property and community: WellElder staff also believed that the program benefited other groups beyond the residents, including family members, property managers, discharge planners, paramedics, and in-home supportive services aides (Sanders & Stone, 2011). Property managers felt that the program benefited the property because it minimized the time staff spent dealing with resident issues. It also reduced resident turnover and potential property damage/resident disruption of the community. The property managers believed that the health educator should spend more time at each location.

Challenges and strategies: One challenge WellElder staff faced was in attempting resident follow-up during a hospital visit (Sanders & Stone, 2011). They did not always know where residents were taken to because there are multiple hospitals in the area and different insurance providers. Some discharge planners were unwilling to discuss the resident's situation with WellElder staff. To address this, staff formed relationships with some hospital discharge planners.

Another challenge was serving residents with mental health issues, including dementia.

Cultural and ethnic differences: The WellElder staff believed Russian and Chinese residents were well-connected to community services and resources. The San Francisco property health educator believed Russian residents were on top of managing their own health and support needs and did not access her for assistance frequently. The same health educator felt that Chinese residents did utilize her more frequently, coming to her for blood pressure monitoring. Multiple WellElder staff at different locations felt Chinese residents were proactive in getting health needs met. On health educator felt that, because the service coordinator was Chinese-speaking, residents utilized her services (the health educator) because the coordinator could help to interpret. In a property with a Russian-speaking service coordinator, Russian residents did not utilize her services as often, but were frequently engaged with the service coordinator. Some of the staff interviewed perceived White and African-American residents to be less knowledgeable about resource options. At times they were also reluctant to accept services. Staff felt they needed to do more outreach to White and African-American residents to encourage participation in services.

Other residents who wanted to maintain their independence were also difficult to serve. Program staff reported that they could have helped those residents avert a crisis, but the resident did not let them.

The study suggested several recommendations for improvement, including:

- Expanding the health educator's hours.
- Clarifying the health educator's role.
- Assuming a more proactive role in assisting the residents.

- Formalizing transition assistance.

- Clarifying program ownership and authority (clarity was lacking around who the owners of the WellElder program were and who had authority to give the program direction).

- Eliminating the concept of program membership (residents who participated in focus groups did not actually know or were familiar with what the "WellElder Program" was and did not know they were members. The rationale for "membership" was unclear--no eligibility requirements to join the program. Stone and Sanders (2011) suggested that the program might be better received *if it was just a service to all residents and not a "membership" program.*

Work Where You Live: A Case Study of the Annapolis Housing Authority

Program model: In 2010, the Lewin Group, through the Centers for Medicare and Medicaid Services (CMS) National Direct Service Workforce Resource Center, conducted a case study of the Housing Authority of the City of Annapolis (HACA), Maryland (Lewin Group, 2009). While serving as the Housing Authority's Director of Senior and Disabled Services, from 1996 to 2002, Renee Kneppar designed and implemented an innovative model of recruiting workers to provide HACA overcame challenges in recruiting personal care assistants to provide needed services to tenants and others living in the local community. The Work Where You Live Program was implemented at the Glenwood High-rise property, a 154 unit, mixed-population building. Eligible residents were age 62 and over or younger adults with disabilities and their families.

Challenge and strategy: Recruiting and retaining workers to provide services is a challenge across long-term services and supports settings. Findings workers to provide services in congregate housing can be particularly challenging, due to the stigma associated with public housing. Hiring a worker can be made more affordable by arranging for the same worker to assist a number of people in the same community. Ms. Kneppar used the Work Where You Live concept to recruit and retain direct service staff into the Congregate Housing Program. She pursued hiring employees who lived in the development and in other nearby subsidized housing.

Several actions taking by Ms. Kneppar and other factors made it convenient and cost-effective to find and keep employees using this model: (1) recruiting staff by advertising on the bulletin board, using the HACA newsletter, and mostly by word-of-mouth; (2) communicating that working would result in a substantive increase in disposable income; the income would not go primarily to increased rent; (3) counseling employees on applying to the Housing Authority for self-sufficiency incentives, such as the Earned Income Disallowance, which would delay rent increases; (4) the approach of

employees working where they live made getting to work very easy for employees; Ms. Kneppar promoted the fact that transportation to work and to training was not an obstacle; (5) flexible work hours were available and promoted; (6) Ms. Kneppar assisted employees with accessing a variety of benefit programs for which they qualified, including Maryland Pharmacy Assistance, Medicaid, local health clinics, and emergency funds available through public and private agencies; (7) providing supportive supervision--Ms. Kneppar recommended that supervisors show appreciation for staff and demonstrate a willingness to perform the same tasks that all employees are expected to perform.

Results: A total of approximately 8-10 personal care attendants (PCAs) were hired during Ms. Kneppar's tenure from 1996 to 2002. The PCAs lived throughout the Annapolis Housing Authority complexes. The workers included healthy older people or people with mild disabilities who lived in Glenwood or across the street at College Creek.

At first, the PCAs were employed by the Housing Authority and had benefits. Later, they were shifted to being employed via yearly contracts, with paid time off but no health benefits. Frequently, the workers voluntarily checked in on the individuals they served during their off hours. They worked an average of 10-28 hours a week. Most of the PCAs stayed, and turnover was minimal.

Medication management was a challenge. In Maryland, unlicensed staff could remind participants to self-administer their medications, but could not manage their medications in any way. Often nurse case managers from the AAA or family members provided this assistance.

Another challenge was matching workers with individuals receiving services. Generally, the PCAs worked with the same people. When a person preferred to have a different PCA, adjustments were made as needed.

Overall, this approach benefitted people with disabilities by helping them remain in a community setting. It also benefited Public Housing and Voucher Programs by encouraging employment and increasing self-sufficiency by making it more convenient and cost-effective for potential employees to become employed and diminishing obstacles to employment.

Considerations for expanding this approach to other settings: Ms. Kneppar advised that this approach is much more likely to work in Housing Authorities that have a service coordinator who is knowledgeable about residents' needs and partners with the community, rather than a building manager only. Also, she suggested exploring opportunities to coordinate with state Congregate Housing and/or Moving to Work programs.

Suggested outreach strategies to consider included: (1) HUD could potentially send letters to PHA Executive Directors encouraging the promotion of the initiative and

cooperation with direct service organizations; (2) State Medicaid agencies may choose to partner with local government and private health care agencies to work in conjunction with housing authorities; (3) direct service organizations might contact PHA Directors to establish a PHA coordinator or other social service employee to promote the program internally; and (4) a Housing Agency could contact direct service organizations to partner to share the information pertaining to the initiative via agency newsletters, posters, or speaking at resident meetings.

Psychogeriatric Assessment and Treatment in City Housing (PATCH)

Program model: Rabins et al. (2000) studied a nurse-based mobile outreach program to mentally ill elderly individuals for six urban public housing sites in Baltimore, Maryland. This model educated building staff to be case finders, performed assessments in residents' apartments, and provided care when needed. Researchers conducted a prospective randomized trial from 1993 to 1996 to assess the PATCH model's effectiveness. Three buildings received the PATCH model, and three received usual care. The study examined if the program was more effective than usual care in decreasing depression levels, psychiatric symptoms, and undesirable outcomes like nursing home placement.

The PATCH model targets older adults living in urban public housing developments (Rabins et al., 2000). Building workers or "indigenous workers" served as case finders. They identified if a resident was at risk of psychiatric disorder and referred them to the psychiatric nurse, who evaluated and treated them in their homes. Case finders included managers, social workers, groundskeepers, and janitors to identify those at risk of a psychiatric disorder and potentially in need of treatment.

The services most often provided by the nurses included counseling the patient, patient education, being a liaison with their one site social worker, medication assistance, monitoring medication side effects, and referral for physical health problems (Rabins et al., 2000).

Impacts for residents: Rabins et al. (2000) found at 26 months' follow-up, based on weighted data, the number of psychiatric cases in the intervention buildings had lowered significantly. Depressive symptoms also lowered significantly, and psychiatric symptoms and behavioral disorder symptoms lowered significantly in comparison to the sites receiving usual care.

No significant difference was seen between the groups in undesirable moves (e.g., nursing home placement, eviction, board, and care placement) (Rabins et al., 2000).

Challenges and strategies: The study did not list specific challenges; however, the authors highlighted the importance of the PATCH model approach: training

individuals who were in daily contact with the older adult was very important to determining if they needed more assistance (Rabins et al., 2000).

The authors noted that Medicare policy reimburses home care, but only for those who are homebound (Rabins et al., 2000). This program demonstrates that persons with serious and persistent mental illness can benefit from this approach, supporting the need to extend the Medicare home care benefit to cover mental health care.

Just for Us

Program model: The Just for Us program provides primary care, care management, and mental health services delivered to medically fragile, low-income seniors and disabled adults subsidized housing residents in their apartments, using available public reimbursement (Yaggy et al., 2006). It was created through a collaboration between Duke University Medical Center; Lincoln Community Health Center; the City of Durham Department of Social Services, the local area mental health entity; and the Durham Housing Authority (Lyn & Johnson, 2011).

The program organizes multiple agencies under one administrative umbrella to participants living independently in clustered housing (Yaggy et al., 2006). In-home care services are provided by an interagency interdisciplinary team, through an innovative administrative structure that coordinates and leverages existing resources. The care team includes primary care providers, social workers, a geriatric psychiatrist and licensed clinical social worker, and a part-time doctor of pharmacy, led by a medical director. A part-time nutritionist, occupational therapist, and phlebotomist complete the team.

Because of Medicare reimbursement, only those with an "access impediment," that is, inability to get to a primary care provider, are eligible (Yaggy et al., 2006).

Clinicians carry laptops when they visit residents, and electronic records are available to all clinicians (Yaggy et al., 2006). To facilitate coordination of care with the hospital emergency department, the program developed computer software to identify Just for Us patients who arrive at the emergency department or are admitted to either of the two Durham hospitals. The system helps hospital staff discharge Just for Us patients home and ensure that they have needed services and food.

Impacts for residents: A 2005 study conducted by Yaggy et al. (2006) of the Just for Us program found the program improved resident health.

Cost impacts: Yaggy et al. (2006) found the program shifted Medicaid expenditures away from ambulances and hospital services to pharmacy, personal care, and outpatient visits. At two-year follow-up, the program was not breaking even, but it was moving toward that goal.

Challenges and strategies: The study identified two aspects of Just for Us that seemed important in explaining client and provider buy-in. First, the model was flexible--clients were not required to participate in an entire package of services, and they did not have to leave their homes. Second, the program enhances the existing capacity of service agencies.

Funding realities prevented the Just for Us concept from being realized fully. For example, intensive case management services were available only to those receiving services through the Older Americans Act or a Medicaid waiver program. In the course of a year, only 100 of the 281 Just for Us enrollees qualified for this case management; those who did not received more limited case management.

A similar challenge was that the program emphasizes primary care and preventive care, neither of which is adequately financed. Both Medicaid and Medicare measure need for services using difficulties with ADLs, but deficiencies in IADLs are key reasons why frail elderly individuals are unable to remain independent. Just for Us addresses IADLs through the inclusion of a part-time nutritionist and occupational therapist. These services were grant funded, because neither Medicaid nor Medicare would reimburse them outside an acute episode or renal failure. This part of the program therefore was not self-sustaining.

The study noted that the financial viability of Just for Us depended on some core elements: an electronic information system for scheduling and medical charts, minimal support staff, use of less costly nurse practitioners or physician assistants, and clustered housing sites to save travel time.

APPENDIX B: FINDINGS FROM SIMILAR PROGRAMS IN OTHER SETTINGS

Aging in Place (AIP) Program

Program model: As part of the AIP program, a partnership between the University of Missouri Sinclair School of Nursing (MU SSON) and the Missouri Department of Health and Senior Services, the University of Missouri-Columbia (MU) developed the TigerPlace project to help seniors "age in place" in an independent senior living community near the campus that was specifically designed to accommodate aging in place (Rantz et al., 2005; Rantz et al., 2008a). CMS funded a pilot and evaluation of the program. Some of the primary objectives for residents were helping older adults stay healthy and active longer, avoiding hospitalization, and relocation to a nursing home (Rantz et al., 2005).

The community consists of 33 apartments for seniors. The building plan team included nurses, physicians, physical therapists, occupational therapists, environmental design specialists, and older adult consumers. The program was designed to help seniors stay active, health, and avoid nursing home placement. TigerPlace is built to nursing home standards; however, it includes additional amenities like private garages and very nice common spaces. Additionally, pets are welcome at TigerPlace.

The organization Senior Care was formed to provide home care agency services (Marek et al., 2005). They became a Missouri Care Options (MCO) provider. The AIP program clients were assigned a nurse care coordinator. This coordinator provided intensive post-acute Medicare home health care; they also followed clients through the MCO program to ensure that their needs were met after they stabilized. The coordinators also identified barriers to care and helped to coordinate services to meet the needs of the frail older adults. They worked closely with primary care physicians and other health care providers to develop a plan of care, in partnership with the client. Staff perform ongoing resident needs assessments and health promotion activities.

Sinclair Home Care provides health care and promotions services to TigerPlace residents (Rantz et al., 2008a). MU SSON developed this home care agency to support aging in place, using $2 million in CMS funds.

TigerPlace is being used by students and researchers as a good location for technology research (Rantz et al., 2008a). This includes ways to monitor and access potential mobility and cognition problems in older adult residents. Their team is developing an integrated sensor network.

In 2011, Rantz et al. provided the results of a 4-year evaluation (described in more detail below) of the program at TigerPlace and another Missouri AIP program. They

reported that the income levels of the research sample in both settings were considerably higher than publicly assisted senior housing residents.

Cost impacts: Rantz et al. (2011) conducted a 4-year evaluation of the AIP program in two long-term care settings in Missouri (one was TigerPlace, another was a continuing care retirement community [CCRC]). These settings had RN care coordination. They were compared to national data for traditional long-term care costs.

Results showed that the combined care and housing costs for residents who received enhanced AIP services and who qualified for nursing home care never approached or exceeded nursing home care costs at the two locations in the study. The costs of the AIP program in both settings were substantially below nursing home costs and in the CCRC setting were several thousand dollars per year less than the national assisted living cost.

Impacts for residents: In a 2005 study of TigerPlace, researchers matched 78 AIP clients with 78 nursing home residents on admission period, ADLs, cognitive status, and age (Marek et al., 2005). Minimum Data Set data were collected over two years, every six months. Results indicated that AIP participants' clinical outcomes were better for cognition at 6, 12, and 18 months; depression at 6 and 12 months; ADLs at 6, 12, and 24 months; and incontinence at 24 months. These were the statistically significant outcomes. In these four outcomes (cognition, depression, ADL, and incontinence), the AIP group stabilized or improved their outcome scores; the nursing home group's scores deteriorated.

In the 2011 evaluation results, measures of mental health (Mini-Mental State Examination, Geriatric Depression Scale, SF-12 MH) and physical health (SF-12 PH, ADL, and Fall Risk) indicated that the AIP model for long-term care was effective for restoring health and fostering independence (Rantz et al., 2011).

Finally, residents of the AIP program at both locations gave the program/facilities high marks for satisfaction (Rantz et al., 2011).

Challenges and strategies: Early in the project, the research team conducted focus groups with residents to assess their attitudes toward technology (Rantz et al., 2008a). They found that residents would benefit from technologies that monitor activity level and sleep patterns, preventing/detecting falls, and caregiver alerts in emergencies. Residents did not want burdensome or obtrusive technology systems.

The challenge in developing this technology was that researchers were no longer working in lab settings; rather, they were in home settings and needed to be cognizant of aesthetics (Rantz et al., 2008a).

A primary lesson learned was fostering collaborative relationships between the partners involved in this effort (Rantz et al., 2008b). In this case, that included public, state, and private partners.

Sinclair Home Care, the home care agency, utilized an electronic information system, and this helped nurses better coordinate care (Rantz et al., 2008b).

Rantz et al. (2008b) also note that one of the advantages of TigerPlace was having a school of nursing undertake the project. Nursing students and other students can benefit from the relationship between MU and TigerPlace.

The authors suggest revisiting the idea of applying the AIP model to public congregate housing (Rantz et al., 2008). They suggest that a low-income of TigerPlace could be achieved if health care is supplemented by Medicaid In-Home Services Program funds. Additionally funding would be needed for RN coordination--in Missouri (and other states), Medicaid funding does not cover this service.

Rantz et al. (2011) recommended changing long-term care regulations in order to make AIP programs possible nationwide. The authors argued that residents should be allowed to remain in independent housing with services or assisted living facilities as their health deteriorates, not be forced to relocate when this occurs.

NORC Supportive Service Program (N-SSP)

Program model: Lawler (2001) provided a case study on Penn South NORC, a community in the Chelsea area of Manhattan and a more detailed full report. The case study site is the community is where the term “Naturally Occurring Retirement Community” was coined, after a co-op board investigated possible strategies for bringing services to senior residents. They set up the Penn South Program for Seniors (PSPS) which selected agencies to provide programs and services to the NORC. As of 2001, 14 NORCs were operating in New York under the N-SSP legislation. Between fiscal years 2002 and 2005, AOA provided grant funding that financed 41 N-SSP projects in 25 states (Colello, 2007).

The PSPS provides many services that help older adults age in place, including care coordination of services, home care coordination and non-acute nursing care, health education and preventative services to name a few.

Cost Impacts: The New York N-SSPs forestalled a reported 460 hospital stays and 317 nursing home placements, saving the state $11 million over 3 years.

Challenges and strategies: Hallmarks of NORC services programs are: the active engagement of tenants in governance of the program and identifying service needs (in some case tenants also pay a membership fee that entitles them to a group of services); a partnership between property managers, tenants and community agencies to bring services to the properties; and the energized involvement of volunteers in decision making and programming (Enguidanos, Pynoos, Diepenbrock & Alexman, 2010).

Engquist, Johnson, and Johnson (2010) reviewed the potential of NORCs with a Program for All Inclusive Care for the Elderly (PACE)-like model. They reviewed N-SSPs, which assist residents with health and social services that may delay or prevent institutionalization, promoting "aging in place." Some of the distinct characteristics of these N-SSPs, which include the following: the provision of a range of health care/social services to match the needs of seniors; making these services available to all seniors in that community, without consideration of health or income; offering these services on the housing site and in the senior's home; having neighborhood associations, housing corporations and health/social service providers collaborate to ensure program success. The services provided by N-SSPs include case management/assistance and social work services, health care management which includes assessments, disease prevention and health promotion, and chronic condition management assistance. Additionally, N-SSPs provide educational and recreational activities and volunteer opportunities. The authors discuss the potential for NORCs to accomplish goals including the promotion of consumer-directed care and delaying or averting ER visits and nursing facility admissions.

In a NORC PACE-like Model, as outlined by the authors, all the services provided by N-SSP and by PACE would be provided; however, this program would be flexible enough to meet the needs/preferences of participants. The facility within the NORC site would be rent-free/bricks and mortar and would be used for delivering primary and acute care, adult day care and other PACE activities. In this model, eligibility criteria would be 55+ and residing in (or near) the complex/service area. The article provides additional details on funding and governance in this model.

A proposed delivery model to support successful aging in place is to establish an integrated set of supportive services for NORC residents. Ormond et al. (2004) report on this potential through reviewing existing literature, discussions with national NORC experts, and conducting five NORC case studies with NORC sites and associated service programs from five AOA demonstration sites. The researchers found that AOA grantees felt that NORC sites presented problems for older residents in terms of accessibility. At all of the sites, service agencies had difficulty with building manager and resident acceptance because their services were started by the agency and not by the NORC residents. Additionally, they found that the AOA grantees provided services including transportation, reduction of physical barriers, and learning/socializing opportunities. Services like home health care or mental health were more often addressed through referrals.

The researchers examined ways that SSPs can help older adults living in senior communities age in place. They found that many of the sites were able to address short-term goals through the programs; however, they needed to work toward long-term outcomes. They suggest that supportive services need to evolve along with the needs of the community, and two-way communication between residents and program staff can foster that. Another suggestion is to measure outcomes. Ormond et al. (2004) also stress that supportive services program cannot address every issue in a NORC; rather,

public institutions may have to address programs such as paving sidewalks. They suggest that SSPs educate the community about these needs. A final discussion point is that of expanding supportive services programs to less densely settled communities. Some of the sites that attempted to serve residents in single-family houses experienced difficulty. The researchers suggest that programs in urban areas or suburban communities adjacent to urban areas could ease implementation problems.

APPENDIX C: FINDINGS FROM WORKSHOPS AND SUMMITS

Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population

Interview overview: Lawler (2001) conducted 60 interviews with senior service providers across the United States and reviewed the lessons learned that emerged from the interviews.

Challenges and strategies: The concerns these health and housing professionals expressed included: (1) Aging in Place in a Rural versus Urban Context--in both areas, providers worked with limited resources. Rural providers felt their communities were better at helping seniors age in place; however, when they are in need of institutional support, the facilities may not be able to accommodate. A lack of housing was a concern for urban providers; however, they were concerned about the inadequate number of support services for older adults; (2) Understanding the Market for Assisted-Living Facilities--community groups should be turned to to understand the market for supportive living facilities; (3) The physical deterioration of a house can cause mental health deterioration--directors of home repair programs mentioned that providing this service helped the older adult feel more in control; (4) Partnerships to deliver services--Lawler (2001) quoted a provider in saying "We are good at housing, we are not good at delivering services." Community-based housing providers felt comfortable in meeting housing needs of local seniors, but not service needs; therefore, they partnered with other service providers to fill these caps; and (5) Partnerships can occur in a variety of places--interviewees pointed out that community-based organizations that collaborated successfully with local health providers ended up working on multiple ventures together in the future.

Regional Workshops on Affordable Housing Plus Services Strategies for Low and Modest-Income Seniors, 2006

Workshop overview: In 2005, AAHSA (now LeadingAge) convened four invitational workshops across the country, which brought together 230 stakeholders from 14 states to discuss the development of affordable housing plus services strategies (Harahan, Sanders, & Stone, 2006b).

Program models: The workgroups resulted in three reports, including an "Inventory of Affordable Housing Plus Services Strategies" document, which identified several affordable housing plus services program models, summarized below (Institute for the Future of Aging Services [IFAS]/AAHSA, 2006).

- Privately financed housing plus services strategies.

    - These strategies include *Housing Cooperatives*, where individuals own shares in a corporation that owns or controls the land and buildings that provide the housing. Services in these locations can be informal or formal, which would involve the joint purchase of services and/or a coordinated and managed services program. Some examples include the Penn South Cooperative and PSPS and the 7500 York Cooperative in Edina, Minnesota.

    - Another strategy includes *Shared Housing*, where two or more unrelated individuals live together in a private single-family home or in a property with commons paces. Another option is *Accessory Housing*, where a separate private living unit is adjacent to a main home. Some examples include HomeShare Vermont and the Pat Crowley House in Chicago.

    - *Mobile Home Parks and Manufactured Home Communities* are another example of privately financed housing plus services strategies. In this model, the housing unit is owned by the individual, but the lots are leased. When there is a high concentration of seniors in these mobile communities, finding ways to bring services to older adults is a strategy to assist with aging in place. Some examples include Millennium Housing and Leisureville Mobile Home Park in California.

    - *Single Room Occupancy (SRO) Hotels* are a final strategy among privately financed housing with services. This is a residential building that rents small private rooms on a weekly or monthly basis to lower-income individuals. There are typically common/shared spaces in SROs. Some examples include Project Hotel Alert in Los Angeles and the Capri Hotel and Sara Frances Hometrel/Transitional Housing for Displaced Seniors program in San Diego.

- Publicly subsidized housing plus services strategies.

    - *Co-Location and Volunteerism* is a strategy where housing providers/managers may work with community groups to encourage the co-location of supportive services in proximity to the housing property. This can include a Title III meals site, a senior center, or health and wellness programs. Some examples include the Golden West Senior Residence in Boulder, Colorado or Koinonia Apartments in Lenoir, North Carolina.

    - *Service Coordination* is a strategy that includes a property manager/housing sponsor employing a staff person to help residents identify service needs, link them to those services in the community, advocate for their receipt of services and educate residents. Examples of these services include the

National Church Residences in Columbus and Schwenkfeld Manor in Lansdale, Pennsylvania.

- *Integrated Care Coordination and Enriched Services* involves offering older residents a formal assessment of function, health status, and service needs. Those who are found to be frail and/or disabled and who have unmet needs are offered a formal services plan, which is coordinated and monitored by property staff in collaboration with services agencies and providers in the community.

- *Integrated Health Care and Supportive Services* involves a purposeful collaboration between low-income housing properties, neighborhood health care providers, and aging services providers. This collaboration can assist low-income senior residents in independent housing in accessing health and long-term care services. The availability of adult day care and/or adult day health care in a co-located space or a nearby property helps make this strategy successful. Examples include presentation Senior Housing in San Francisco and Over 60 Heath Center/Centers for Elders Independence/ Mable Howard Apartments in Oakland, California.

- *Linking NORCs to formal service programs* is a strategy for affordable housing plus services. The development of service delivery programs helps respond to the needs of aging tenants. Some examples of this include Vladeck Cares/N-SSP in New York.

- *State Supportive Services Programs Linked to Publicly Subsidized Housing* is another strategy to promote affordable housing with services. Often, the goal of state supportive housing programs is to reduce Medicaid nursing home costs through helping older adults remain in independent housing for longer. This requires the state housing agency, the state's aging and health agencies and the housing properties to collaborate. A state agency selects providers to deliver a range of services to participating housing properties, which can include case management, Medicaid HCBS waivers, home care, and medication management. Examples of this include the Connecticut Congregate Housing for the Elderly.

- *Assisted Living as a Services Program* is another strategy. Assisted living can be licensed as a service, and not a physical entity, in some states. These services, typically provided by a home health agency, can be provided by the property or contracted out. These services include 24-hour available personal care, medication management, meal preparation, housekeeping and laundry and transportation. Connecticut is a state that uses this strategy.

- A *Campus Network Strategy* links independent housing for older adults with a licensed assisted living facility. The housing property and the assisted living

facility typically provide services separately. An example of this is Cathedral Square Senior Living in Burlington, Vermont.

- *Affordable Housing/Health Systems Partnership* are a final strategy listed in this inventory. A health system and an affordable housing sponsor establish a formal partnership to expand the supply of affordable housing with services. This partnership could also link health services to existing affordable housing. The health systems can bring primary care and health-related services to older residents. Services provided include health screenings, care management, wellness programs, and geriatric assessments to name a few. Examples of these programs are the Sixty Plus Program in Atlanta.

Challenges and strategies: The workshop report listed four pre-requisites of a successful strategy: (1) the commitment of housing providers to a broader role; (2) partnerships between the housing provider and the surrounding community; (3) persistence and creativity; and (4) the need for a catalyst.

The obstacles included licensing and regulation, liability, fair housing laws, difficulty bridging housing and aging services, finding funding for resources, a limited understanding of some housing providers to meet service needs of residents, opposition of residents, affordability and nursing home influence (Harahan, Sanders, & Stone, 2006b).

National Summit on Affordable Senior Housing and Services, May 2010

Workshop overview: This summit was hosted by AAHSA in partnership with Enterprise Community Partners, Inc., with support from Evercare United Healthcare Group, the McGregor Foundation, and JP Morgan Chase. This summit brought together policy makers from government, housing and long-term care providers, and other key stakeholders. The goals were to share ideas, successful strategies, and planned policy initiatives to develop affordable senior housing with services; to identify barriers to the development of this model, and to identify next steps.

Program models: A discussion from this summit was on the essential components of a successful housing with services strategy. Participants determined that this model would need to be resident-centered, allow resident's choice in services received, include assessments for resident status and needs, include service coordination/care management, include a viable and accessible design for the physical structure, and have access to quality services for residents.

The drivers participants identified to actually facilitate the development of this program model included the need for a catalyst or champion, effective partnerships, sustainable funding mechanisms, flexible models, and adequate workforce.

The desired outcomes of this model include the following: Lowering transfer to higher levels of care; lowering ER visits and hospital stays, better chronic disease management and better transition out of the hospital to the property; improved medication management; improving physical functioning; improving mental health; reducing and preventing falls; enhancing resident physical activity; reducing lifestyle barriers through health/wellness activities and better nutrition; reducing isolation; improving a sense of security, and enabling residents to live in their apartments for as long as they choose (AAHSA, 2010).

Challenges and strategies: The participants raised questions and concerns related to developing this model, which included the concern over the availability of health services, retrofitting older buildings, single funding streams, and technology in a housing with services model.

Barriers identified include regulations, funding, liability, culture and capacity, fragmentation of local services, a silo mentality, eligibility requirements (like Medicaid waivers), the need for data on resident characteristics, and limited knowledge on affordable housing settings (AAHSA, 2010).

Recommendations: Participants also identified next steps to begin developing this housing with services model. Some of these steps were related to conducting research/investigation; including how housing with services models fit into health care reform and how these strategies can address dual eligible populations through health care reform and other initiatives. The summit suggests continuing to work collectively on developing a design demonstration and acquiring the funding needed to test the effectiveness of different housing with services models. A typology of these programs/strategies should be developed to help stakeholders understand how these models can be constructed. The summit also suggested the development of common language/definitions to communicate these goals to policymakers, regulators, and funders. Additionally, defining the core elements most likely to influence desired outcomes was a next step (AAHSA, 2010).

Summit on Aging in Public Housing, March 2011

The purpose of the summit was to examine opportunities and strategies for meeting health/ supportive needs of senior residents in public housing. Enterprise Community Partners, Inc. and LeadingAge (2011) identified three goals.

Workshop overview: This summit was hosted by Enterprise Community Partners, Inc. and LeadingAge. It was supported by the Atlantic Philanthropies. This summit included chosen representatives from PHAs, service providers, and public housing residents. The purpose of the summit was to examine opportunities and

strategies for meeting health/supportive needs of senior residents in public housing. Enterprise Community Partners, Inc. and LeadingAge (2011) identified three goals:

1. Explore effective strategies for how PHAs and service providers can work together to support the needs of aging residents to meet their health and supportive needs and remain safely in their home.

2. Engage resident participation in developing and advocating for the types of service programs they would like to see in their housing community.

3. Ignite interest and commitment from participants to continue to work together on next steps.

Program models: During a breakout group discussion, residents, service providers, and housing providers discussed the elements needed for a public housing with services model. The elements identified by residents were necessary supports, better individual needs assessments, compassion from housing staff, increased safety and senior-only buildings. Service providers indicated that there needed to be a system of services set up, a public health model that addresses all needs and not just high-risk targeting, sustainable funding, evidence-based strategies, a learning circle collaborative, and that the housing authority view themselves as a part of the service network. Finally, housing providers stated that they needed better information on resident needs, more flexibility/autonomy to ask residents questions about their situations, to move them where they can be better served, and to allow for sound business decisions. They highlighted the need for universal design and accessibility upgrades, sustainable funding for core services, full-funded service coordinators, and transportation (Enterprise Community Partners, Inc. & LeadingAge, 2011).

Challenges and strategies: Participants from the summit included PHAs, residents, and service provider partners from Atlanta, Brattleboro, Vermont, Denver, Chicago, Milwaukee, New York, and Oklahoma City. These participants shared their strategies for bringing health and supportive services to residents. They include resident assessments, the development of partnership networks, policy efforts including participation in a larger Medicare demonstration activity (Vermont), and resident engagement.

This summit also included resident perspectives--those involved were highly engaged and they raised the following points: residents have a desire to be engaged in their community; they are invested in it. They felt that they provide a support network to one another. Additionally, they want to feel greater compassion from housing staff. Residents also believe that their inside perspective can be valuable to assisting properties in identifying resident needs (Enterprise Community Partners, Inc. & LeadingAge, 2011).

When asked about challenges and needed policy/practice reforms, all three stakeholder groups identified these. Residents felt that reaching seniors not living in

senior-only buildings was a challenge and that older adult and younger disabled population living together was a challenge. Service providers stated that there needed to be a policy directive or an incentive for the housing authorities to view themselves as a part of the service system and not as a product. Finally, housing providers highlighted a few challenges/reforms which included fair housing and knowing of resident needs, the challenge of resident suspicion when they are collecting information, finding funding for non-Medicaid and lower-risk populations and the complexity of eligibility.

Recommendations: All of the stakeholders also identified ways to measure success of these programs. Residents mentioned increased resident satisfaction, decreased crime, increased safety, reduction in turnover/evictions, and increased resident engagement. Service providers mentioned an improved quality of life, reduced hospital stays, and reduced ER visits. Housing providers stated that measures needed to be standard across entities and they needed to be simple to collect. The measures they suggest are reduced evictions, improved wellness, reduced hospital stays, increased quality of life, and a cost/benefit analysis.

The major findings from the event were the need to reach all elderly residents and to better understand the residents. The summit also highlighted the need for the housing authority to play an increasing/redefined role in providing services. Housing authorities and service providers need to increase their skills and knowledge to better interact with each other and with residents. Some residents expressed concern over the mix of older adult and younger disabled populations due to mental health issues among the younger population. The summit participants also found that housing authorities and their service partners need to be better aware of potential opportunities available for them to support their residents. Finally, most of the participants realized that this model of affordable housing with services is an inevitable path (Enterprise Community Partners, Inc. & LeadingAge, 2011).

DESIGN OF A DEMONSTRATION OF COORDINATED HOUSING, HEALTH AND LONG-TERM CARE SERVICES AND SUPPORTS FOR LOW INCOME OLDER ADULTS

Reports Available

Design of a Demonstration of Coordinated Housing, Health and Long-Term Care Services and Supports for Low-Income Older Adults

HTML	http://aspe.hhs.gov/daltcp/reports/2011/lioaDemo.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2011/lioaDemo.pdf

The “Value Added” of Linking Publicly Assisted Housing for Low-Income Older Adults with Enhanced Services: A Literature Syntheses and Environmental Scan

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2012/ValueAddes.shtml
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